Presented at the Annual Meeting of the Canadian Psychiatric Association, Winnipeg, Manitoba, September 23, 1981.

M-078E
C.2

INVOLUNTARY HOSPITALIZATION TO MENTAL AND PSYCHIATRIC HOSPITALS, AND PSYCHIATRIC UNITS OF GENERAL HOSPITALS, CANADA, 1970-1978

Rodney Riley [1]

Alex Richman, M.D. [2]

INTRODUCTION

There has been considerable discussion and debate in recent years on the issues relating to the involuntary hospitalization of the mentally ill. The professional journals of medicine, law, and psychiatry are continuously publishing articles and editorials on this contentious subject. However, the controversy this topic has engendered has not been restricted to just the professional and scientific community, but has reached the general public through numerous articles published by the press. As a result the practice of involuntary hospitalization is under more public scrutiny than ever before.

In the recent Canadian literature the discussions on involuntary hospitalization have centered around the topics of the medical-legal debate (3,4,11), the criteria for commitment (6,10,12), and the adequacy of

1. Program Manager, Mental Health Program, Institutional Care Statistics Section, Health Division, Statistics Canada, Ottawa, Ontario.
2. Professor of Psychiatry and Preventive Medicine, Faculty of Medicine, Dalhousie University, Halifax, Nova Scotia.

The interpretation of the data and the views expressed are those of the authors only.

provincial mental health legislation (5,7). The majority of these discussions have been related to individual provinces and have in most instances not contained any quantitative information (9). It is the intent of this paper to fill in this empirical gap by presenting national statistical data on involuntary hospitalization to provincial mental and psychiatric hospitals, and psychiatric units of general hospitals for the period 1970-1978. The analysis is restricted to a quantitative examination of admissions to these facilities in terms of medical, demographic, and provincial characteristics. The area of clinical, legal, and public debate on the issues of involuntary hospitalization will not be discussed.

METHODOLOGY

Data Collection

The data used in this study are based on the statistical information on psychiatric inpatients collected by the Mental Health Program of Statistics Canada for the period 1970-1978. This statistical information was derived from individual psychiatric morbidity forms (Appendix I & II) which provincial psychiatric inpatient facilities completed for each person admitted for inpatient treatment. These morbidity forms were filled out by the staff of the medical records department.

The statistical information on psychiatric morbidity collected by Statistics Canada was based on data collected from a wide range of inpatient facilities. For the purposes of this study the data on admissions to psychiatric inpatient facilities were restricted to the provincial mental and psychiatric hospitals and to the provincial psychiatric units of general

hospitals. The reporting universe for these facilities is shown in Table A. For the period under study the reporting universe and the actual number of facilities operating were identical for most of the years covered.

The reporting arrangements with Statistics Canada for provincial mental and psychiatric hospitals and provincial psychiatric units of general hospitals were varied. For the period 1970-1978, the majority of these facilities reported directly to Statistics Canada using the Statistics Canada psychiatric inpatient morbidity forms. In most instances these forms were submitted to Statistics Canada on a monthly basis. Special reporting arrangements did exist with some provincial governments whereby a provincial department submitted their data on psychiatric inpatients via annual tapes for the facilities under their jurisdiction, while others co-ordinated the collection of the data from their facilities and subsequently shipped the completed forms to Statistics Canada.

Data Processing

Upon receipt of the provincial statistical information by Statistics Canada, the data were subjected to a series of manual checks and computer edits. The provincial data was then merged into a single data set for the production of tabulations and reports.[1].

1. Statistics Canada. Mental Health Statistics, Volume I: Institutional Admissions and Separations. Catalogue No. 83-204, Annual, Bilingual.

   Statistics Canada. Mental Health Statistics, Volume II: Patients on Books of Institutions. Catalogue No. 83-208, Annual, Bilingual. (Discontinued after 1976).

Diagnostic Classification

The diagnostic classification used in the Statistics Canada survey for 1970-1978 was based on the International Classification of Diseases, Adapted, 8th Revision (ICDA-8). Primary diagnoses was defined as "the disorder that the attending physician judged to be the main or most important condition for which the individual receives psychiatric services".

The present study is based on selected diagnostic classes of Chapter V of the ICDA-8 on Mental Disorders. Mental retardation (310-315) and alcoholism and alcoholic psychoses (291, 303) were eliminated from the analysis. The remaining diagnostic classes of Chapter V are referred to in this paper as "Diagnostic Group I" and "Diagnostic Group II". (See Appendix IV for a listing of the diagnostic classes and codes for these two groups).

Derivation of Population Estimates

The population data used in the calculation of rates were derived from the Census of Canada and from the Population Estimates of the Demography Division of Statistics Canada.

Type of Admission

The statistical data presented in this paper are based on first admissions and readmissions to mental and psychiatric hospitals and psychiatric units of general hospitals. First admission was defined as the admission to a psychiatric inpatient facility of a person who has no record of previous care in any psychiatric inpatient facility. Readmission was defined as a person who has had previous care in a psychiatric inpatient facility or the

transfer-in of a person to a psychiatric inpatient facility directly from another psychiatric inpatient facility. Total admissions were based on the aggregation of first admissions and readmissions.

Limitations of the Data

Admission data are subject to certain limitations. In some provincial reporting systems, a first admission refers to a patient admitted for the first time to that particular provincial psychiatric inpatient system, regardless of previous care in psychiatric inpatient facilities outside of the system. Readmissions are counts of cases and not patients. For example, one individual readmitted four times during the reporting year would be counted as four readmissions. The total number of admissions, therefore, is somewhat larger than the numbers of persons actually treated.

The data on rates of involuntary admissions for the period 1970-1975 include all the ten provinces for the years 1970-1971. For the years 1972-1975, involuntary admission data are missing from Saskatchewan and the rates for this period were based on the other nine provinces. For the years 1976-1978, the data on commitments to psychiatric inpatients facilities in Quebec are excluded due to coding problems in the reporting of this item.

Method of Admission

During the period 1970-1978 two psychiatric morbidity forms were used by Statistics Canada. For 1970-1975 the information collected on method of admission was divided into three major categories: Informal, Voluntary, and and Involuntary. In 1976 the form was revised and the question on method of

admission was expanded to include: Voluntary, Involuntary: Emergency, Commitment, Lieutenant Governor's Action, Remand, Other. Definitions for these terms are presented in Appendix III.

In our first preliminary analysis we examined method of admission in terms of the two major categories, voluntary and involuntary. However, involuntary admissions as a total are related to a mix of legislative acts and statutes (Criminal Code, Provincial Mental Health Statutes, Penetentiary Act) which encompass such procedures as Lieutenant Governor's Actions, remands, commitments, judicial actions, etc. For the purposes of today's presentation we decided it would be more meaningful, given the time constraint of a conference presentation, to focus on a particular aspect of involuntary admissions. Since the data for 1970-75 only permitted an examination of involuntary admissions as an aggregation, we selected for our detailed analysis the 1976-1978 period. The analysis of the data for 1976-1978 is restricted to commitments to provincial mental and psychiatric hospitals, and provincial psychiatric units of general hospitals. Commitments refer to the compulsory hospitilization of the mentally ill under the criteria specified in provincial mental health legislation and exclude such procedures as emergencies, Lieutenant Governor's Actions, remands, and judicial actions.

It should be pointed out at this juncture that the Mental Health Program of Statistics Canada was revised in 1978 and the program on the submission of psychiatric morbidity forms to Statistics Canada from psychiatric units of general hospitals was terminated. Presently the only information collected at the national level on method of admission, for the years 1979 and onwards, is limited to provincial mental and psychiatric hospitals.

RESULTS

Involuntary Admissions, 1970-1975

Involuntary admissions in Canada decreased from 20,385 in 1970 to 16,113 in 1975 (a 21% decrease). Figure I presents these admissions in terms of rates per 100,000 population for males and females and the total. There is an almost parallel decrease for both male and female involuntary admission rates during this six year period. The involuntary admission rates from 1970 to 1975 were consistently lower for females and by 1975 the rate for females had decreased by 31 per cent while for males the decrease was 17 per cent.

Voluntary admissions during this same period showed a differing pattern from involuntary admissions in terms of both sex and number of admissions. In contrast to involuntary admissions the number of voluntary admission increased from 58,434 in 1970 to 76,434 in 1975 (a 31% increase). A further contrast was the consistently higher voluntary admission rates for females than for males. The rate for females increased from 345 in 1970 to 422 in 1975 (a 22% increase) and for males increased from 275 to 341 (a 24% increase).

This decrease in the number of involuntary admissions and increase in the number of voluntary admissions resulted in a significant decrease during the years 1970-1975 in the proportion of involuntary admissions to the mental and psychiatric hospitals and the psychiatric units. In 1970 involuntary admissions accounted for 24% of the total admission (voluntary and involuntary), while in 1975 involuntary admissions accounted for only 15% of the total admissions.

Commitments, 1976-1978

The number of commitments to Canadian mental and psychiatric hospitals and psychiatric units of general hospitals decreased from 11,392 in 1976 to 10,522 in 1978 while voluntary admissions increased from 69,952 in 1976 to 73,013 in 1978. In terms of rates per 100,000 population commitments decreased by 10% during this period while voluntary admissions increased by 2% (Table B).

The rate of commitments for Diagnostic Groups I and II for the three year period are shown in Figure II. The decrease in the rate of commitments is attributed to the psychotic disorders while commitment rates for the non-psychotic disorders remained stable.

An examination of commitments for 1976-1978 indicates varying provincial patterns. Figure III indicates Nova Scotia having had the highest rate of commitment followed by Prince Edward Island and New Brunswick, while Newfoundland and Manitoba had the lowest rates. The percentage of commitments to total admissions (commitments and voluntary admissions) also show similar provincial patterns as the rates of commitments. Of the total admissions aggregated for the years 1976-1978, Nova Scotia, Prince Edward Island, and New Brunswick had the highest percentages of commitments, while Newfoundland and Ontario had the lowest percentages (Table C).

The distribution of commitments to mental and psychiatric hospitals, and psychiatric units of general hospitals varied between provinces. Figure IV presents the percentage of commitments to psychiatric units aggregated for the years 1976-1978. In Saskatchewan 75% of commitments were admitted to

psychiatric units, followed by 36% in British Columbia, 35% in Manitoba, and 21% in Ontario. For Newfoundland, New Brunswick, and Alberta the percentages were very low. There were no commitments to psychiatric units in Nova Scotia. Prince Edward Island did not have a psychiatric unit during this period.

The percentage distribution of diagnostic classes in Table D indicates that for males and females the largest proportion of commitments were given schizophrenia (295) as a primary diagnoses. The other diagnoses common to commitments were affective psychoses (296), neuroses (300), and the group of personality disorders, etc. (301,302,305,306,308,309).

Age-specific rates for commitments show that the first admission rate was highest for the age group 65 and over for both males and females (Figure V), whereas for voluntary admission the age-specific first admission rates were highest for the age group 20-39. Figure V also clearly illustrates that males had higher first admissions rates than females for commitments but lower first admission rates for voluntary admissions.

First admission rates specific for age, sex, and marital status for commitments and voluntary admissions are presented in Figure VI. In the 15-19 year old age group there was no significant difference in the first admission rates between the single and married categories for both male and female commitments. This pattern changed in the other age groups. Married males and females in the age groups over 19 years of age had the lowest first admission rates for commitments and voluntary admissions than the other marital status categories.

In the 20-39 year age group both the widowed and divorced males and females had the highest first admission rates for commitments and involuntary admissions. However, in the age groups 40-64 and 65 +, first admission rates for commitments and voluntary admissions were generally higher for single males and divorced females.

DISCUSSION

This paper has attempted to provide some statistical highlights on the medical, demographic, and provincial characteristics of involuntary admissions to provincial mental and psychiatric hospitals, and psychiatric units of general hospitals. The data presented for the period 1970-1978 indicate a moderate decline in involuntary admission rates in Canada. However, there are provincial variations in these rates due to differences in the provinces on such factors as mental health acts, regulatory procedures and operational practices, the availability and range of provincial hospital facilities for the treatment of the mentally ill, and political and public attitudes.

The most striking demographic finding of this study was that men had consistently higher involuntary admission rates than women for the period 1970-1978. However, for this same period, women had consistently higher voluntary admission rates than men. This phenomenon may be attributed to several factors. In a recent study of sex differences in psychiatric treatment it was found that women demonstrated a consistent tendency to seek psychiatric help at a higher rate than men with comparable emotional problems (2). In addition, there are significantly more women than men visiting the

offices of private practicing physicians to discuss psychiatric problems (1). Physicians have good access to general hospitals and are able to arrange for the voluntary admission of their patients suffering from mental disorders. In addition, it may be argued that men generally come for treatment at a later stage of their psychiatric illness and thus the severity of their condition makes them less liable to be compliant than women who seek out earlier treatment. It may also be that our culture in general conditions women to be more compliant than men.

An additional factor related to the high involuntary admission rates for men and high voluntary admission rates for women may be related to the provincial criteria for the compulsory hospitilization of the mentally ill. In most provincial mental health legislation the stipulation for compulsory certification implies the element or condition of "dangerousness". It may be that men are more liable to be perceived by physicians as "dangerous" than women with the same psychiatric disorder.

The finding that over one fifth of commitments (22%) were to psychiatric units of general hospitals was somewhat unexpected. Undoubtedly the general hospitals are providing more acute short term care and are assuming the larger share of treatment for hospitalized mental patients. One study showed that for mental disorders, 53% of patient days under four months were spent in general hospitals (8). The data in the present study indicate that psychiatric units of general hospitals were considered by many of the provinces to be "designated facilities" for admissions requiring certification as commitments under provincial mental health legislation.

The high commitment rate for the elderly was another major finding of this study. In many cases the elderly person with a "disorder of the aging" may be living alone and require the supportive care of a nursing home. The mental hospital may become the "place of last resort" if alternate placement in another setting, such as a nursing home, is not available. The elderly person living in a family environment may be perceived as "dangerous to self and others" as psychological symptoms of aging becomes more predominant. In this circumstance, the family may exert considerable pressure on the psychiatrist to commit the aged person to a mental hospital.

The low admission rates in both the voluntary and involuntary admission categories for both married males and females supports the hypothesis that marriage is a selective and protective factor in mental health. The literature on this topic is vast and we will not attempt to open this Pandora's box at today's presentation.

This study is the first national quantitative analysis, both in Canada and in the international literature, of involuntary admissions to mental and psychiatric hospitals, and psychiatric units of general hospitals. The quantitative information presented for the years 1970-1978 should provide a useful empirical backdrop for an historical perspective on this topic. In addition it is hoped that the statistical information for this period will serve as baseline data for further investigations, assist in the assessment of subsequent changes, and provide an heuristic incentive for clinical studies.

REFERENCES

1. d'Arcy, C., Schmitz, J.A. Sex differences in the utilization of health services for psychiatric problems in Saskatchewan. Canadian Journal of Psychiatry. 24: 19-27, 1979.

2. Kesser, R.C., et al. Sex differences in psychiatric help - seeking: evidence from four large scale surveys. Journal of Health and Social Behaviour. 22: 49-64, 1981.

3. McCormick, W. Involuntary commitment in Ontario: some barriers to the provision of proper care. Canadian Medical Association Journal. 124: 715-717, 1981.

4. McCready, J., Merskey, H. Compliance by physicians with the 1978 Ontario Mental Health Act. Canadian Medical Association Journal. 124: 719-724, 1981.

5. Miller, A. The Ontario Mental Health Act, 1978. A comment on its application. Canadian Journal of Psychiatry. 24: 515-518, 1979.

6. O'Keefe, G. Criteria for committal: a continuing controversy. Ontario Medical Review. 46: 169-170, 1979.

7. Page, S., Firth, J. Civil commitment practices in 1977. Troubled semantics and/or troubled psychiatry. Canadian Journal of Psychiatry. 24: 329-334, 1979.

8. Richman, A. Atlas of specialized psychiatric inpatient care. Unpublished study, 1981.

9. Richman, A., Poulos, H., Riley, R. Compulsory Treatment of Mental Illness in the Atlantic Provinces. Paper presented at the Annual Meeting of the Atlantic Psychiatric Association, October, 1979.

10. Sherrington, A. Difficulties in commitment of the mentally ill. Editorial. Canadian Medical Association Journal. 124: 663-664, 1979.

11. Toews, J., Prabhu, V., El-Guebaly, N. Commitment of the mentally ill. Canadian Journal of Psychiatry. 25: 611-618, 1980.

12. Vincent, M. Commentary on: Civil Commitment practices in 1977. Canadian Journal of Psychiatry. 24: 334-335, 1979.

Table A. Reporting Universe, Mental and Psychiatric Hospitals and Psychiatric Units of General Hospitals, by Province and Type of Facility, Canada, 1970-1978

Province	Mental and psychiatric hospitals									Psychiatric units of general hospitals								
	1970	1971	1972	1973	1974	1975	1976	1977	1978	1970	1971	1972	1973	1974	1975	1976	1977	1978
Canada	62	61	60	56	57	59	58	55	54	86	91	91	99	116	129	135	149	146
Nfld.	1	1	1	1	1	1	1	1	1	1	1	1	1	2	5	6	7	7
P.E.I.	1	1	1	1	1	1	1	1	1	-	-	-	-	-	-	-	-	-
N.S.	5	5	5	5	5	5	5	5	5	3	3	3	3	4	3	3	3	3
N.B.	2	2	2	2	2	2	2	2	2	2	2	2	4	4	4	3	4	4
Que.	17	16	16	16	16	18	18	17	17	22	23	22	27	29	33	32	34	33*
Ont.	23	23	23	22	22	21	20	19	18	41	43	43	43	48	50	53	60	61
Man.	4	4	4	3	3	3	3	3	3	4	5	5	5	5	5	5	5	5
Sask.	3	3	2	2	2	2	2	2	2	5	5	5	5	5	5	5	5	5
Alta.	4	4	4	2	2	2	2	2	2	5	5	6	5	8	8	9	9	9
B.C.	2	2	2	2	3	4	4	3	3	3	4	4	6	11	16	19	22	19

* Reported for the first three months of 1978.

41000

Table B. Commitments and Voluntary Admissions, Mental and Psychiatric Hospitals and Psychiatric Units of General Hospitals, by Sex and Method of Admission, Canada, 1976-1978

Year		Voluntary admissions			Commitments		
		Male	Female	Total	Male	Female	Total
1976	Number	27,797	42,155	69,952	6,325	5,067	11,392
	Rate *	243	365	304	55	44	50
1977	Number	29,783	42,973	72,756	6,124	4,637	10,761
	Rate *	257	367	312	53	40	46
1978	Number	30,469	42,544	73,013	6,175	4,347	10,522
	Rate *	261	360	311	53	37	45

* Per 100,000 population.

Table C. Percentage of Commitments to Total Voluntary Admissions and Commitments, Mental and Psychiatric Hospitals and Psychiatric Units of General Hospitals, Canada, 1977-1978

Province	Male	Female	Total
Canada	20.0	11.0	14.8
Newfoundland	8.5	6.1	7.4
Prince Edward Island	32.8	25.5	28.8
Nova Scotia	37.6	27.2	31.9
New Brunswick	35.9	22.7	28.9
Ontario	15.8	7.8	11.2
Manitoba	29.0	15.8	21.6
Saskatchewan	19.4	14.8	16.8
Alberta	23.7	12.0	17.1
British Columbia	25.0	14.6	18.9

000015

Table D. Commitments to Psychiatric Units of General Hospitals, Percentage Distribution of Diagnoses, by Sex, Canada, 1976-1978

ICDA-8	Diagnostic Class	Male	Female
		Percentage distribution	Percentage Distribution
290	Senile and presenile dementia	1.1	1.7
292, 293, 294	Psychosis associated with intracranial infections, other cerebral and physical conditions	2.5	3.3
295	Schizophrenia	29.0	29.5
296	Affective psychoses	10.6	16.4
297	Paranoid states	2.4	4.7
298, 299	Other and unspecified psychoses	6.8	8.9
300	Neuroses	11.3	21.1
301, 302, 305, 306, 308, 309	Personality disorders, sexual deviation, physical disorders of presumably psychogenic origin, special symptoms not elsewhere classified, transient situational disturbances, mental disorders not specified as psychotic associated with physical conditions	15.8	12.1
304	Drug dependence	1.0	0.6
793	Observation without need for further medical (psychiatric) care, not stated	19.5	1.7
	Total	100.0	100.0

9100016

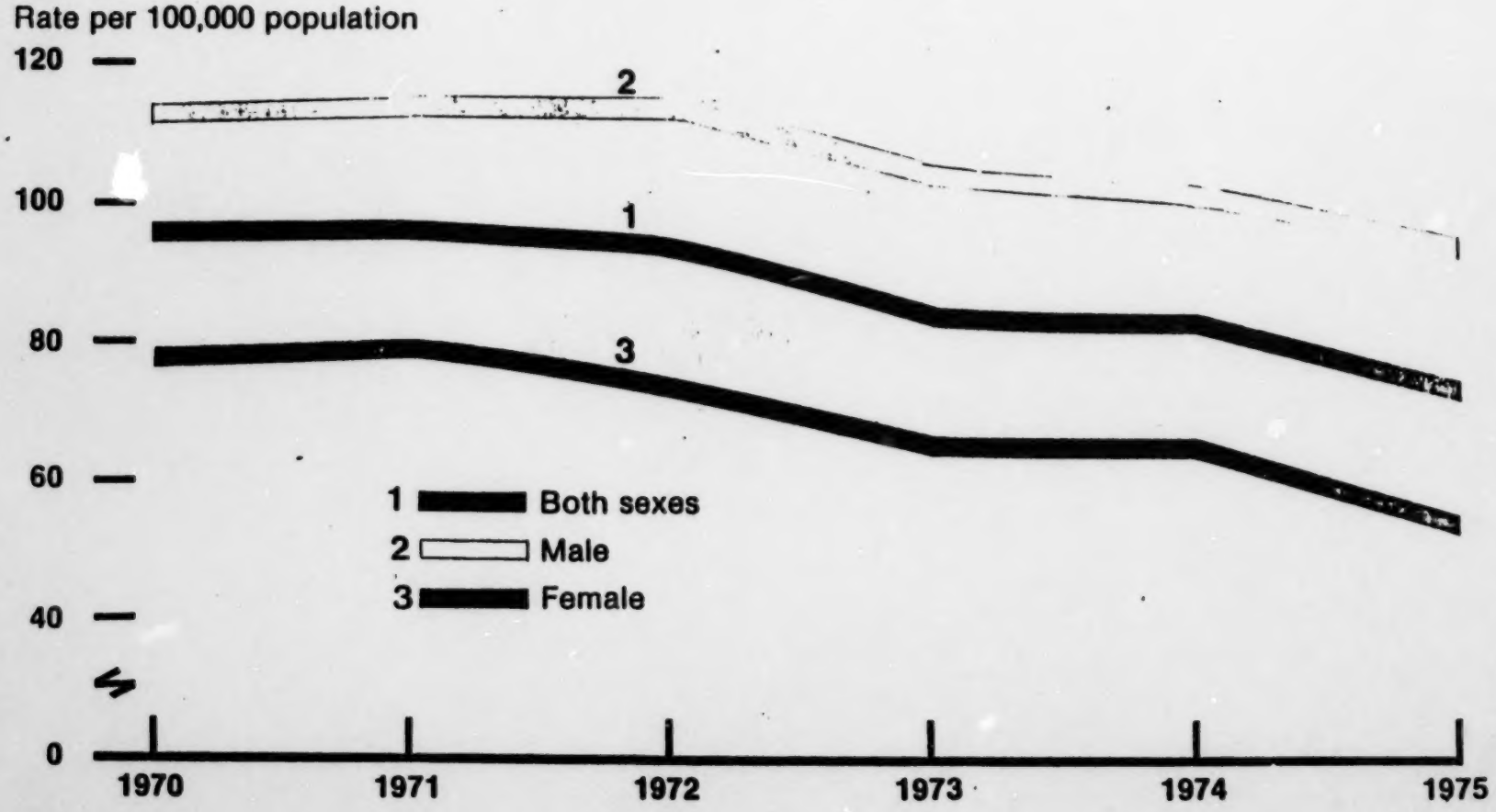
Table D. Commitments to Mental and Psychiatric Hospitals, Percentage Distribution of Diagnoses, by Sex, Canada, 1976-1978

ICDA-8	Diagnostic Class	Male	Female
		Percentage distribution	Percentage distribution
290	Senile and presenile dementia	3.2	4.2
292, 293 294	Psychosis associated with intracranial infections, other cerebral and physical conditions	4.9	3.8
295	Schizophrenia	42.1	34.5
296	Affective psychoses	9.9	14.5
297	Paranoid states	2.1	2.8
298, 299	Other and unspecified psychoses	5.1	5.6
300	Neuroses	7.4	11.2
301, 302, 305, 306, 308, 309	Personality disorders, sexual deviation, physical disorders of presumably psychogenic origin, special symptoms not elsewhere classified, transient situational disturbances, mental disorders not specified as psychotic associated with physical conditions	21.1	19.5
304	Drug dependence	1.8	1.4
793	Observation without need for further medical (psychiatric) care, not stated	2.4	2.5
	Total	100.0	100.0

CIHI

FIGURE I

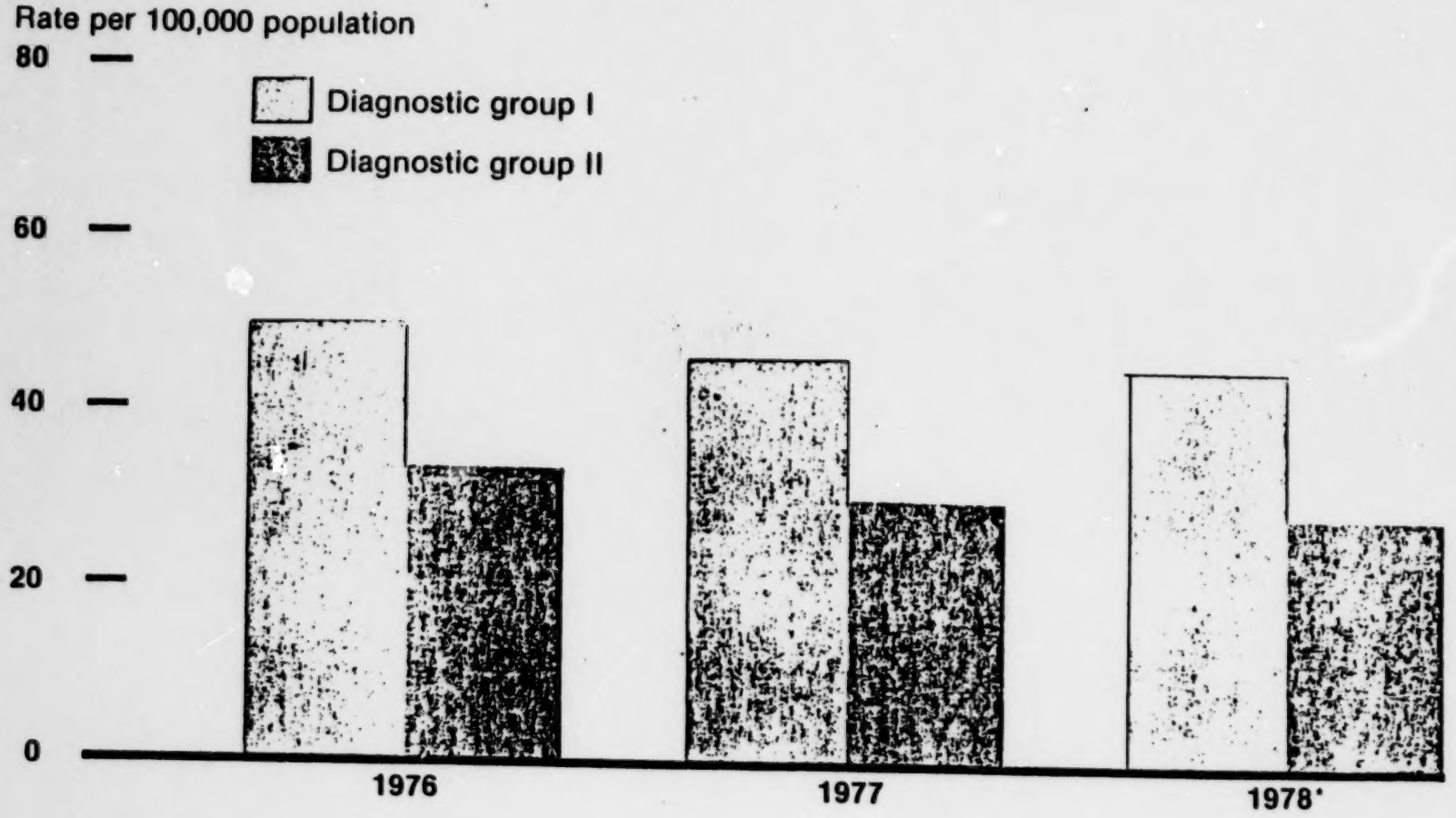
Involuntary Admissions, Canada, 1970-1975



Total rates for 1972-1975 based on nine provinces (Saskatchewan not included).

FIGURE II

Commitments, Total Admissions, Canada, 1976-1978



610000

FIGURE III

Commitments, Diagnostic Group I, by Province, Canada, 1976-1978

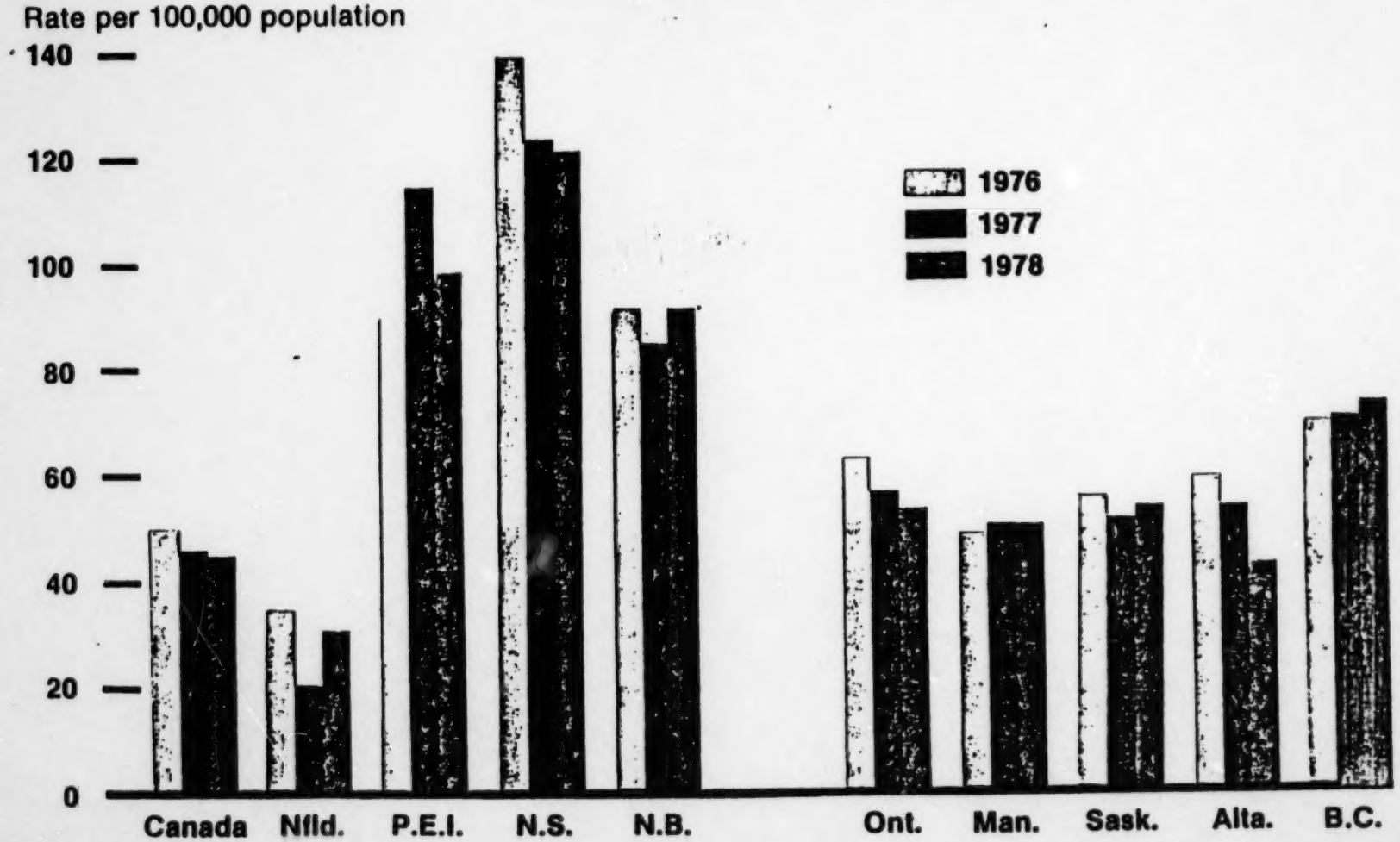
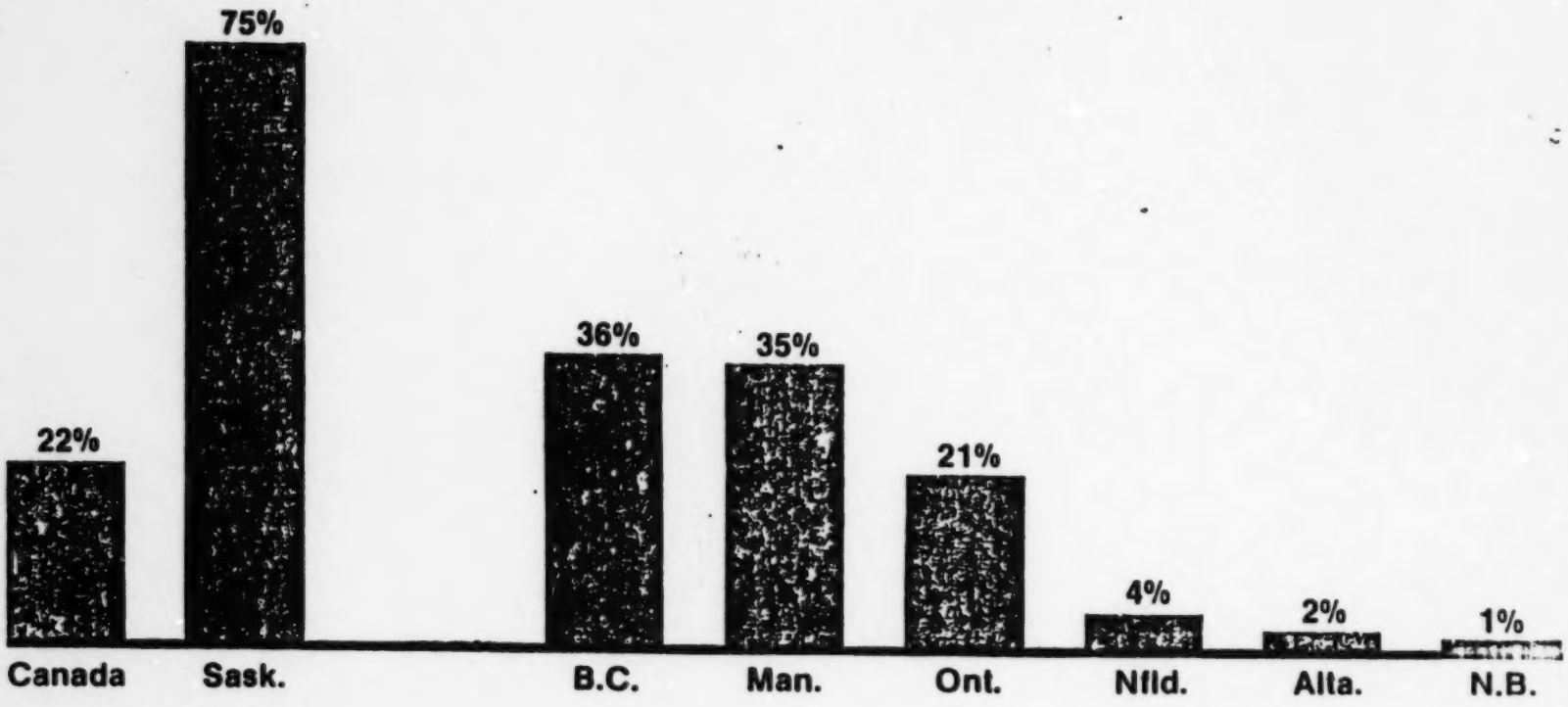


FIGURE IV

Percentage of Commitments** to Psychiatric Units of General Hospitals, Canada, 1976-1978 Diagnostic Group I



** Percentage of commitments calculated on total admissions to mental and psychiatric hospitals, and psychiatric units of general hospitals.

FIGURE V

First Admission, by Method of Admission Sex and Age, Diagnostic Group I, Canada, 1978

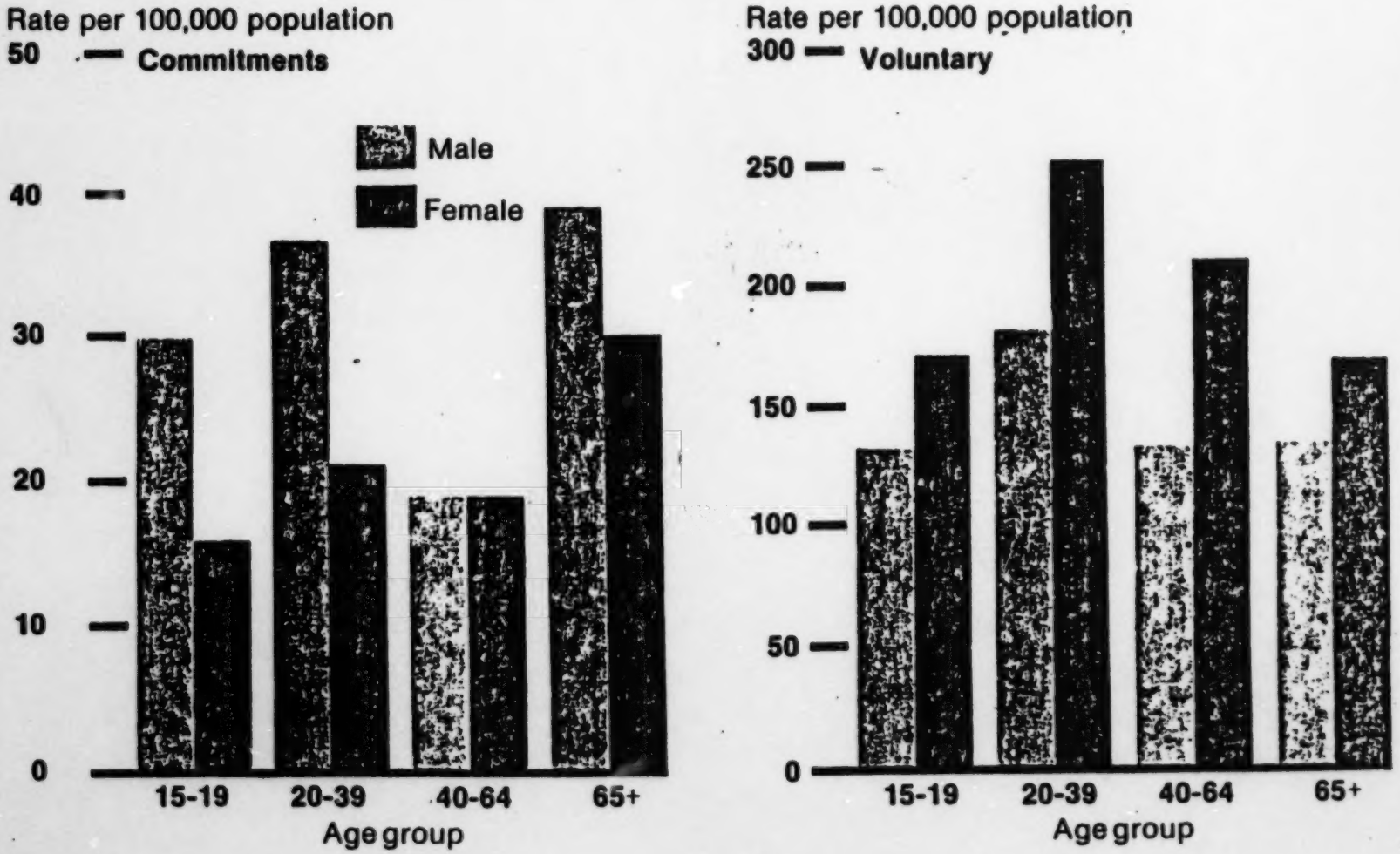


FIGURE VI

First Admission, by Marital Status, Method of Admission, Age and Sex, Diagnostic Group I, Canada, 1978

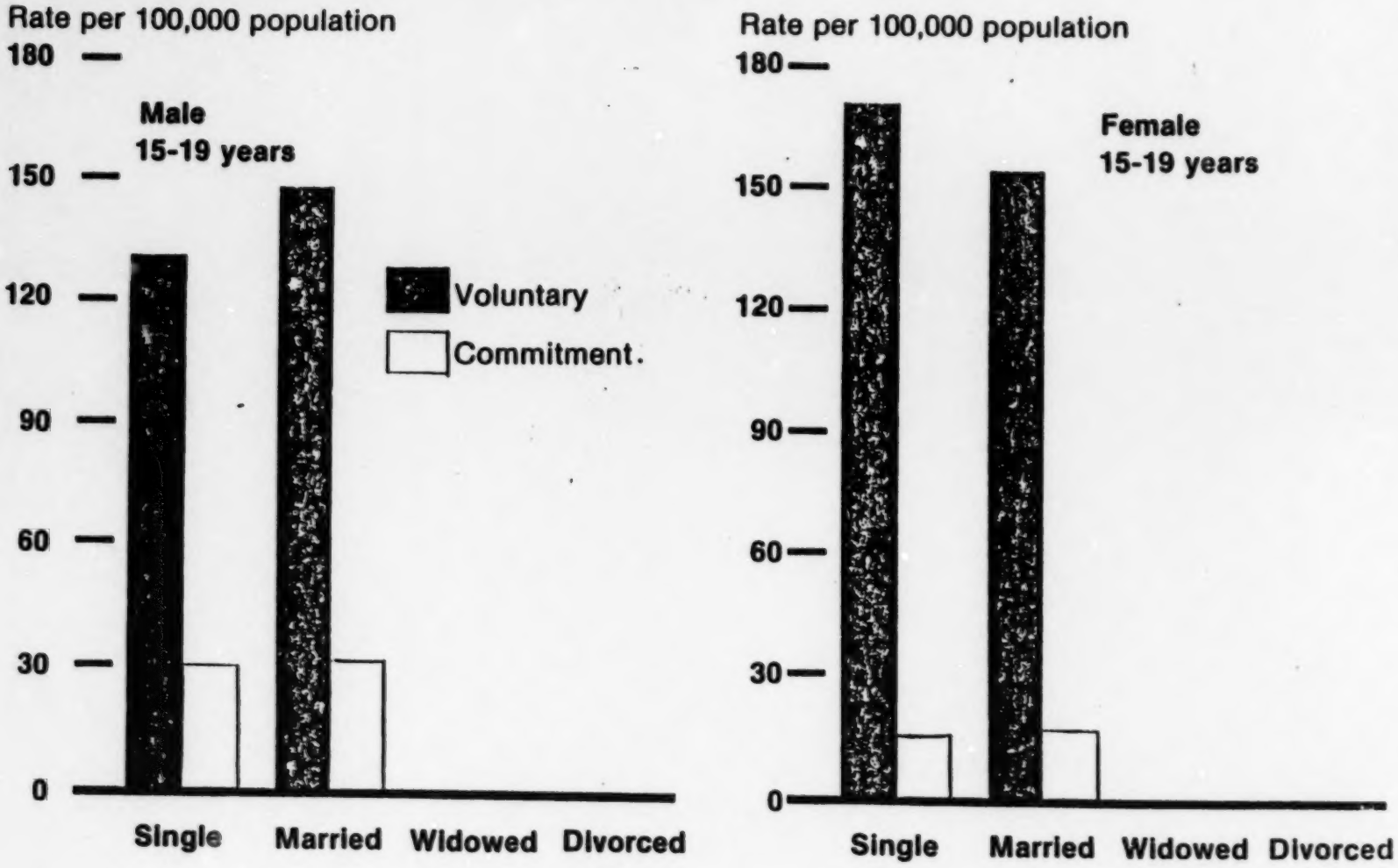


FIGURE VI (Continued)

First Admission, by Marital Status, Method of Admission, Age and Sex, Diagnostic Group I, Canada, 1978

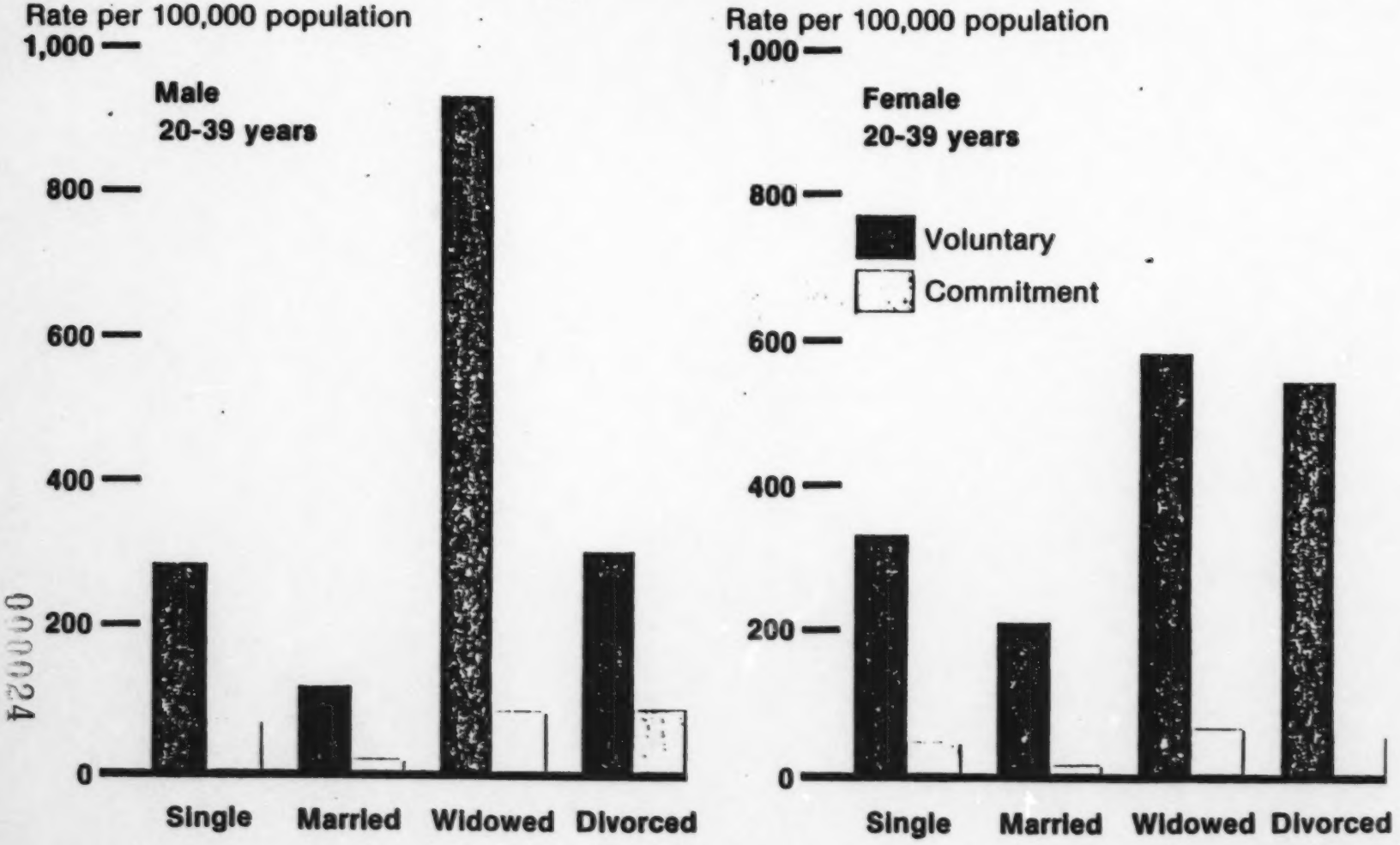


FIGURE VI (Continued)

First Admission, by Marital Status, Method of Age and Sex, Diagnostic Group I, Canada, 1978

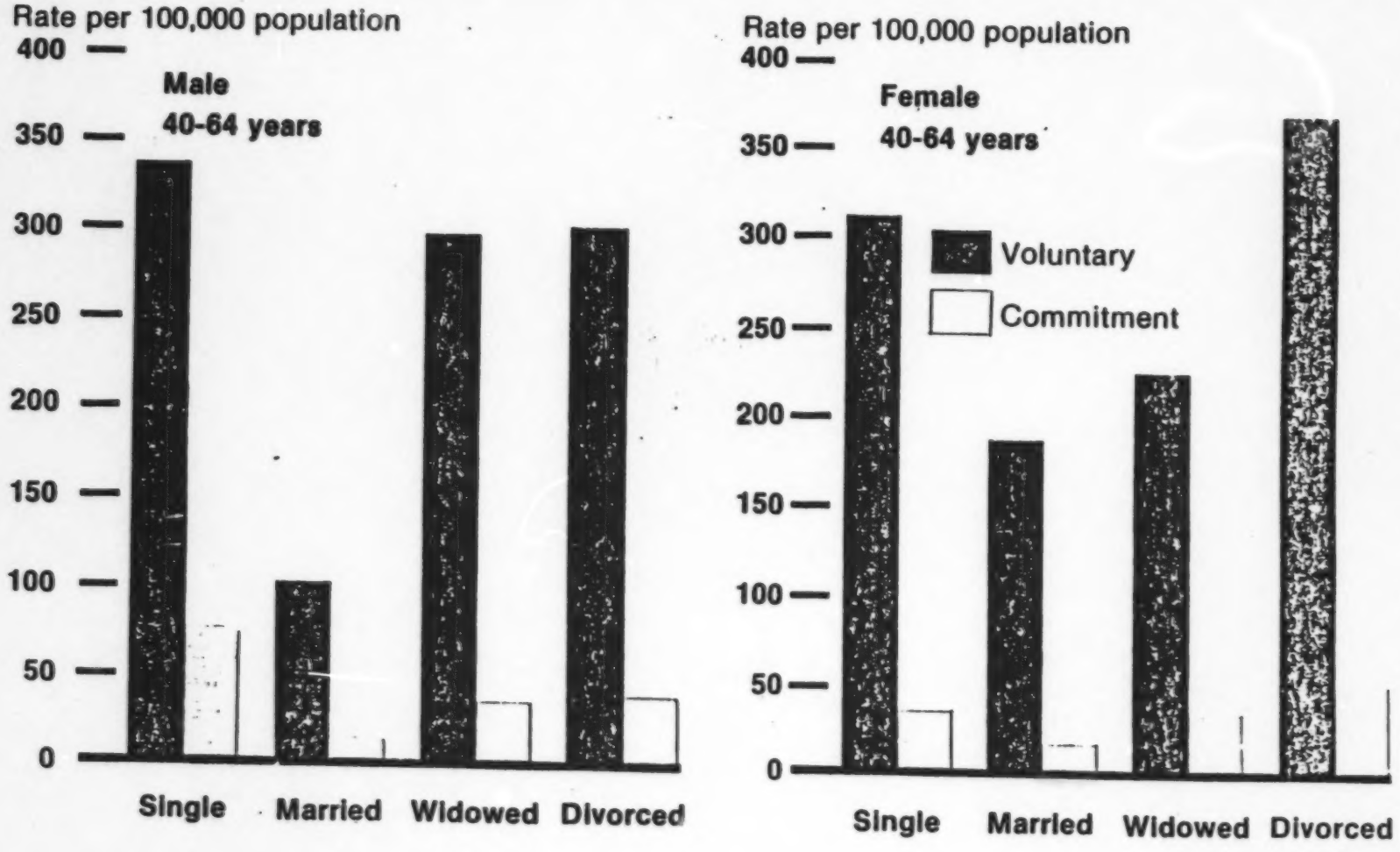
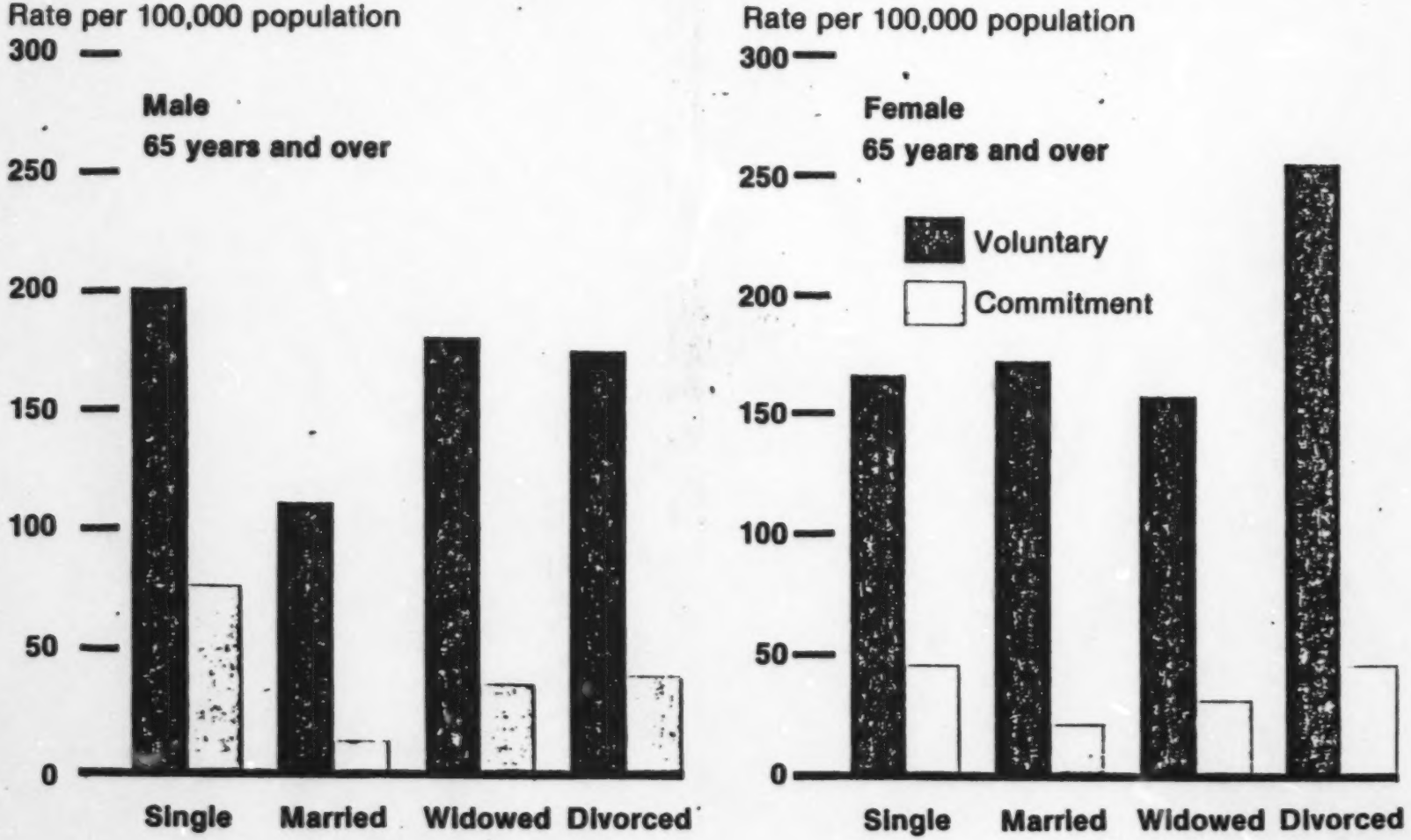


FIGURE VI (Concluded)

First Admission, by Marital Status, Method of Admission, Age and Sex, Diagnostic Group I, Canada, 1978



APPENDIX I

Statistics Canada

Psychiatric Morbidity Form, 1970-1975

PSYCHIATRIC ADMISSION

1. Sex [1] ☐ Male [2] ☐ Female 2. Case No. _____

3. Name of patient: (Surname) (Given name) 4. Date of admission: (Day – month – year)

5. Residence: (City, town, village, rural municipality) (County)

6. Age: Date of birth: (Day – month – year)

7. Marital status: [1] ☐ Single [2] ☐ Married or separated [3] ☐ Widowed [4] ☐ Divorced

8. Born in Canada: ☐ Yes. If "no" state year of arrival in Canada _____

9. Religion: [10] ☐ Angl. [20] ☐ Bapt. [40] ☐ Luth. [50] ☐ Pres. [60] ☐ Rom. Cath. [80] ☐ United Church Other (specify) _____

10. Occupation: 11. Industry:

12. Highest grade of school ever attended: [0] ☐ None [1] ☐ Elem. 1-4 [2] ☐ Elem. 5+ [3] ☐ Sec. 1-3 [4] ☐ Sec. 4+ [5] ☐ University [6] ☐ Univ. degree

13. Method of admission: [1] ☐ Voluntary [2] ☐ Involuntary [9] ☐ Informal Specify statute

14. Did the patient come directly from a psychiatric in-patient or residential facility? No ☐ If "Yes", name the institution:

Date of admission to this institution:

15. Was the patient ever before an in-patient in a psychiatric institution or residential facility? (Disregard the experience recorded in Item 14):

☐ Yes ☐ No No. of times _____

If "Yes" give particulars of latest stay:

Date of discharge: (Day – month – year)

Name of institution:

16. (i) Principal psychiatric diagnosis (describe fully):

_____ I.C.D. No. _____

(ii) Other psychiatric diagnosis:

T, TR. D. Disc. D.

9000–91. I: 19-9-67

Leave blank for use by D.B.S. all spaces within broken lines

000027

APPENDIX II

Statistics Canada

Psychiatric Morbidity Form, 1976-1978

F 100127

2 Facility No | | |

APPENDIX III

Instruction Manual Definitions, 1976-1978

5. Method of Admission: Check the appropriate box. Mark one box only.

(1) VOLUNTARY, INFORMAL – Persons admitted on either a voluntary or informal basis.

INVOLUNTARY:

(2) Emergency – Refers to persons detained in a facility for observation, examination and general assessment, but not admitted for further care or treatment.

(3) Commitment – This category is to be used for involuntary admmissions to a facility (excluding Lieutenant Governor's Action and Remand for Examination).

(4) Lieutenant Governor's Action – This will apply to any person admitted to a facility on the basis of a warrant or order issued under the authority of the Lieutenant Governor.

(5) Remand for Examination – This category will be utilized for persons remanded for observation by court order pursuant to either the Criminal Code (Canada), or when applicable, any statute embodying remand provisions (e.g., the particular provincial mental health statute).

(6) Other (Specify) – Enter specific statute or act.